

TRANSITION PERIOD (July 1 until waiver is enacted)

- Q1. The Division of Health Care Financing (DHCF) has advised families about hour cutbacks to 15 hours per week. How will those hours be broken down across line staff, Seniors, Lead therapist, team meetings, and overlap?**
- A. Prior to issuing the prior authorization amendments, we contacted each of the main lead therapists who work for the various providers. Each main lead therapist gave us instructions on how to distribute the 15 hours. Since the amendments were done, a number of providers have requested re-amendments to the amendments, and we will be issuing re-amendments to reflect the changes. Medicaid does not distinguish team meeting from direct service hours, so team meeting hours are included as part of the 15 hours per week.
- Q2. Under card service rules, we were allowed 5 hours of Senior time each week. Can we still utilize that level of service if we want?**
- A. Providers have requested up to 3 hours of senior therapist time, and have been granted these hours.
- Q3. Team meetings are very important, but they will use up a lot of billable hours. What are the rules about frequency of team meetings during the transition period?**
- A. The frequency of team meetings is determined between the family and provider, not by Medicaid. The only Medicaid requirement concerning team meetings is that the child must be present for the time to be billed.
- Q4. Some families would like more Senior time for consulting purposes. Other families feel comfortable with parents serving as Seniors and would rather use all their hours for line therapy. Can families decide what is best for their individual situation during this transition period, as long as they stay within the 15 hours per week maximum?**
- A. Yes. Medicaid only expects documentation for those services that Medicaid reimburses. Although there are no requirements for a certain amount of hours by each professional level, Medicaid still expects that the responsibility of supervision of line staff is met. This may be met by having the parent serve as the senior therapist, supervising the line staff.
- Q5. Many families are getting cut to 15 hours per week during the transition period. Is this an average of 15 hours per week? For example, if we go on**

vacation one week, can we make up the lost hours during the following week for an average of 15 hours?

- A. The number of hours that are granted under PA is based on a “per week” basis only. You can not make up for missed therapy hours during a different week.

Q6. If 15 hours per week is a maximum, without any averaging across weeks, and we go over 15 hours in a week, will I be charged for the hours over 15? Who will charge me? At what rate would I be charged?

- A. Services in excess of those authorized are considered noncovered services and can be provided to the family *if* the family agrees to receive and pay for the additional services. Then, the provider may bill the family. The rate is negotiated between the family and provider. Medicaid has no authority regarding rates for noncovered services. .

Q7. The 15 hours we get during the transitional period will cost more than \$28.60 per day, which will be the daily rate after the waiver goes into effect. By using more than \$28.60 per day now, during the transition period, will my child receive less than \$28.60 per day for the remainder of the fiscal year?

- A. The daily rate does not apply until the waivers are ready to be implemented and a plan is developed for the services a family will need. Services are determined on an individual basis. This process takes into account desired outcomes for the child and the services necessary to meet those needs. Therefore, individual service plans may be less than the \$28.60 per day.

There is a set budget of \$26.5 million available for the biennium (July 1, 2003 – June 30, 2005) to provide the intensive autism services. Therefore, it is necessary to have savings in the current Medicaid Card covered service system. The state calculated the budget for this transitional period with children who have had more than three years of intensive services receiving 15 hours at a maximum. This assumed that children would move to intensive waiver services at the average of \$96.00/day or the ongoing waiver at the average \$28.60/day rate no later than November 1, 2003.

This means that current cost containment measures are needed to assure these daily rates on the waivers. If we overspend in the first few months, daily rates will need to be lowered. Appeals for increased hours may affect these daily rates as the Department of Health and Family Services must manage within the given budget.

Q8. What other service options are available to my child during this transition period? It would be helpful if DHFS would send us a list.

A. Medicaid would cover other services as long as they are not duplicative and are medically necessary. Refer to the Medicaid website for a description of Medicaid-covered services. The website is www.dhfs.state.wi.us/medicaid.

Q9. I worry that my child may require short term out of home placement once his therapy is reduced to 15 hours per week. Are there any service providers we can call if we need help, and will the services be Medicaid-eligible expenses?

A. The only Medicaid-coverable out-of-home placements would be hospital and nursing home. These services would need to be medically necessary. For assistance about resources in your area, please contact your local county human services agency.

Q10. I have heard that DHFS is not allowing any new kids to begin intensive services until the waiver begins. Is this true?

A. This is not true.

Q11. I have also heard that once the waiver is approved and enacted, it will be retroactive 3 months. What exactly does this mean?

A. Retroactive billing can occur for existing waivers currently operated by the counties. This is because these waivers have been approved by the federal Medicaid agency. However, the children's waivers are brand new waiver applications – and until approved by the federal government, they doesn't exist, technically. Once the waiver is approved, services can be offered and billing can take place, but there can be no retroactive billing for a new waiver, because it did not exist previously. Families are involved in plan development and will be asked to sign the plan so that you will know the date that the change in funding will take place for your child.

Q12. “If my child is ready to start in-home autism therapy for the first time, can we start now, or do we have to wait for the waiver to be in place?”

A. If a child meets the criteria for intensive in-home therapy in the next several months, the provider should work with the Medicaid Prior Authorization unit for having initial services authorized. Once the waivers are approved by CMS and available to families these children will also have their plans transitioned to the Children's Waiver. For all children

receiving services when the new waivers are available, the county will initiate contact with them.

In the future, new families will contact either their county agency or the state Bureau of Developmental Disabilities Services to initiate service requests. An independent assessment will be required prior to the initiation of the intensive in-home autism services. The Division of Health Care Financing is developing these evaluation teams and the criteria they will use in the next several months.

Q13. My provider is requiring a minimum number of therapy hours that is far greater than the 15 hours my child has been cut back to, and has indicated that therapy will be discontinued if we can't pay for the required hours over 15. Is this legal? Is there anyone we can or should contact to report this, or to get assistance?

A. Providers are allowed to make treatment recommendations in excess of services that will be covered by Medicaid, or any other insurer. In this case, treatment hours that exceed the number of hours above what are authorized under the PA are considered non-covered services and thus may be billed to the recipient, as long as the recipient is made aware of that fact prior to the delivery of service. A provider is not required to charge the same cared service rate for services above and beyond MA covered services. A provider may refuse to serve a child whose parents cannot afford the extra hours. A family may go to another provider for services.

Q14. What are my options if my provider does not want to do a 15 hour program? Can I have my child's PA transferred to a new provider without long delays?

A. Yes. The new provider will need to submit a new PA. All PAs are acted upon within two weeks providing that the provider completes the PA request accurately and completely.

Q15. What are my appeal rights if I choose to appeal the cutback in hours during the transition period?

A. Information about appeal rights were sent to all families, along with the reduction in hours notification. Details of appeal rights and responsibilities are included at the end of this document. Families who have already filed appeals will receive notification about a hearing date. See attachment.

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CURRENT AND FUTURE FUNDING

Q16. I've been told that the "waiver year" will start when the Children's Waiver is approved and activated (maybe in Nov '03). Does this mean that we won't start using the \$26.5 million until November, and if so, where is the money coming from for the current transition period?

- A. The \$26.5 million in state General Purpose Revenue is a "*sum certain*" budget, meaning it is the entire amount of state funding for *in-home autism services (both card services and waiver services)* for the 2003-05 biennium. The biennium started on July 1, 2003 and ends on June 30, 2005. Since this is a sum certain amount of funding, the use of funding in the current Medicaid fee-for-service system affects the amount of funding that *will be available when the waiver takes effect*.

Q17. I've heard that children will be eligible for \$28.60 per day during the post-intensive period. Does that mean my child will receive \$28.60 per day only for each day that he receives services?

- A. On average, children who qualify for an ongoing post- intensive slot will have \$28.60 per day to spend for waiver approved services. However, the \$28.60 per day is not an entitlement amount. Services will be individually planned to meet each child's individual needs – and the State expects that some children will need less than \$28.60 per day to meet their goals, whereas other children may need slightly more. This means that some plans may have a lower daily value, and some may have a slightly higher daily value.

Q18-A. Assuming my child qualifies for funding, I am counting on the \$28.60 per day to help pay for continuing ongoing therapy, which we will subsidize with our own money. For budgeting purposes, can I plan on my child receiving \$28.60 per day?

- A. No. The County will work with the child's family (and, as desired by the family, the child's service provider) to develop a service plan based on the assessed need of the child. When that is completed the County will develop a budget up to the \$28.60 per day.

Q.18-B. Who does the county work with if the child does not have a provider to develop a service plan? I want to save as many dollars for direct services and want the waiver to pay therapists directly.

- A. The County will have a service coordinator assigned to work with the child's family in the ongoing waiver (Post intensive) families will have a lot of flexibility regarding the providers of services. Some services will need to have therapist supervision, others can be managed directly under the supervision of the family. The service coordinator can talk with families about what they would like to have happen and then determine how this is done under the waiver.

Q19. I have been told more than once that my child is guaranteed \$10,000 of support per year until he is 22, as long as he continues to meet the guidelines for Medicaid eligibility. Is this really true?

- A. No. As noted previously, plans are developed on an individual basis. The \$10,000 per year is not an entitlement; it is the maximum amount of funding that may be used to fund the child's individual support plan. In some cases, the cost of a child's support plan may be lower than \$10,000, based on the assessed needs of the child. The Children's waiver does continue through to the child's 22nd birthday, as long as they continue to meet level of care eligibility criteria.

Q20. If the number of kids entering the waiver continues to increase, but the amount of funding for the program stays the same, then won't my child's slice of the pie get smaller?

- A. No. The State has budgeted for 250 new children to enter into intensive level services each year of the biennium. If we need more funding to serve children already receiving services, this may affect the number of new slots available. The State will regulate new admission and develop a waiting list for new admissions if necessary. Therefore, if the use of funds by current families exceeds the daily rates available on the intensive and ongoing waivers then there may not be adequate funding to serve as many new children in the future. The State anticipates that we will be able to manage funding such that new children will be able to start without waiting.

Q21. Even if the State has allocated a certain number of "slots" for new kids to receive intensive services, there will still be many kids transitioning to post-intensive services – and once they are there, it's likely that they won't transition out for many years. If there is a growing number of kids in the

post-intensive program but still the same amount of funding, won't my child's slice of the pie get smaller?

- A. Once children are on the waiver, for either intensive or ongoing services, they have a right to continue to receive services. Therefore they will be transitioned without waiting. We have budgeted for new children to come on at the rate of 250 children per year. We have projected adequate funding for this biennium and the next biennium to continue to include new children. In the future additional funding may be needed to admit new children. Children do age out of the waivers at age 22 years and this funding will then return to new children entering.

Q22. Is the amount (\$10,000) really a guaranteed amount? Won't the amount of money available each year depend on how much money is approved in the State budget?

- A. The Intensive In-home Autism funding is budgeted through fiscal year 2004, which ends June 30, 2005. The \$26.5 million in State funding is expected to be available on an ongoing basis. A child who is eligible for the ongoing, post –intensive slots will be eligible for up to a maximum of \$10, 000 of services per year. For the next biennial budget (fiscal year 2005-06), the Bureau of Developmental Disabilities will request additional funding if needed to permit new children to receive intensive services.

Q23. I understand that the waiver is automatically renewable, which means the structure for the waiver will continue to be intact. However, I've heard that some waivers are "on the books," but have no funding to actually be able to provide the services indicated in the waiver. Does this mean we might have to advocate for funding to fund the waiver every two years?

- A. The current funding is expected to continue into future biennial budgets. Without additional funding, there may be waiting lists for new children to enter intensive services. If there is a need for additional funding for these children in the future, funds will need to be requested through the state biennial budget process.

Q24. Since this is not an autism only waiver will children with other disabilities ever be competing with our kids for these post intensive funds? Could this affect the amount our kids receive under the waiver?

- A. No. The Intensive and ongoing waiver slots are earmarked for children who meet the Autism diagnosis criteria.

Q25. How will waiver fund be earmarked for kids with autism? Will funds be divided up into 3 "pots" – intensive autism, post-intensive autism and general waiver (for kids without autism)?

- A. Waiver slots are divided into four categories. Intensive Autism slots, Ongoing Autism slots, children's redesign slots, and children's waiver local match slots. The funds for intensive autism services and post intensive services will be managed to assure that the needs of current families and new families will be met. The intensive and ongoing slots are managed separately.

COORDINATION OF FUNDING SERVICES

Q26. If my child receives funding through the Children's Waiver, will he lose Family Support funding?

- A. Not necessarily. There is no State rule that would prohibit counties from blending these funding sources if they choose to do so, which would allow families to access both Family Support and the waiver. Each County will be working with their local Family Support Advisory Committees to develop policy and procedures as to how family support funding will interface with the children's waiver.

Q27. If my child receives funding through the Children's Waiver, will he lose the extra additional funding from Family Support's Children Can't Wait program?

- A. The Families Can't Wait Campaign is an effort within Dane County to address the needs of families whose children are on waiting lists. These funds are not governed or regulated by the Department of Health and Family Services. Decisions on the use of these funds will remain with the Family Support and Resource Center in Dane County.

Q28. If my child receives funding through the Children's Waiver, will he lose respite services received through Family Support?

- A. Not necessarily. Each County will be working with their Local Family Support Advisory Committees to develop policies and procedures as to how the Family Support Program will interface with the children's waiver. However, note that respite is one of the services available under the waiver and may be funded by the waiver for children receiving the ongoing, post-intensive slots.

Q29. If my child currently receives in-home autism therapy and Family Support, and if my child can receive funding from only one of these sources, who will make the choice about which funding source to keep – me, the county, or the State?

- A. Decisions like this are negotiated by the county and the family. Counties will not necessarily require families to access just one program or the other. County case managers will determine which funds are available and will help families decide which funding sources are best suited to support the child's needs, if choices between funding sources must be made.

Q30. Even if my child can't receive Family Support while receiving intensive autism therapy, can my child be on the waiting list for Family Support during intensive treatment, since the Family Support waiting list is so long?

- A. Families will need to follow their county's Family Support waiting list policy. Please keep in mind that, at the end of intensive autism therapy, children will automatically transition to the children's waiver, which offers services comparable to the Family Support Program. There is funding available to children under the waiver once they end intensive services.

Q31. Can my child receive services under the Children's waiver in addition to receiving services under the CIP waiver?

- A. No. Federal waiver standards prohibit an individual from participating in more than one Medicaid service waiver at a time. If a child is already on the CIP waiver during the transitional period, the family will need to choose whether they want to switch to the children's waiver or remain on the CIP waiver. Families will get detailed information on the impact of this choice so that they can make an informed decision.

Q32. If my child currently receives in-home autism therapy and CIP, will I have to choose between the Children's waiver and the CIP waiver?

- A. Yes, if your child is still eligible to receive intensive in-home services, this particular support is only available under the children's waiver. If your child is beyond the intensive treatment timeframe, you may want to stay on the CIP waiver and work with your county service coordinator on other supports and services you may need. See Question 34 for information about purchasing services comparable to in-home autism treatment under the CIP waiver.

Q33. If my child currently receives in-home autism therapy and CIP, and if my child can participate in only one waiver, who will make the choice about which waiver to keep – me, the county, or the State?

- A. The family will have the ability to choose the waiver in which their child participates.

Q34. If my child currently receives CIP, can we purchase in-home autism services from providers through that funding source?

A. Yes. Although the intensive in-home services are only available under the children's waiver, comparable services can be accessed through "counseling and therapeutic resources" on the CIP waiver. All service decisions need to be discussed and approved by the county and remain within the identified daily rate authorized by the child's home county.

Q35. Can my child be on the waiting list for CIP/COP while he is on the Children's waiver?

A. The State does not have a standard waiting list policy. Each County has individual waiting list policies, which will need to be followed. Counties are asked to ensure that participation in the children's waiver not affect the child's opportunity to transition to another waiver as they age out of the children's waiver.

Q36. If my child receives services under the waiver, will he be eligible to receive services under his Medicaid card?

A. Yes. Children can continue to access other medically-necessary Medicaid card services, such as OT, PT, Speech/Language Therapy, Psychotherapy, and Personal Care services. In fact, because the waiver can not be used to fund services which are available under the Medicaid card, these services must be billed to the child's Medicaid card, not to the waiver. The prior authorization process for card-based services must be followed by the family and selected providers.

Q37. Is there any reason (such as "duplication of services") that my child might not be able to access certain card services if he receives services under the waiver?

A. According to Medicaid rules, services funded by a waiver must be different from services available under the Medicaid card, so, by definition, there should not be "duplication of service" issues. However, if the child needs a service that is not funded under the card, such as respite or after school care; or if the child's need for a service exceeds the amount available under the Medicaid card, for example the child is approved for 15 hours of personal care as medically necessary but needs 20 hours per week due to family needs, the waiver plan could include the five additional hours needed as supportive home care. These supportive home care services would complement Medicaid card personal care services.

Q38. Are particular card services, such as SED, likely to be considered a duplication of services, and therefore be denied to a child who is receiving services under the waiver?

A. The waiver cannot fund services which are available under the Medicaid card. However, if the child needs a service that is not funded or the child's need for a service exceeds the amount available under Medicaid, the waiver plan can include services that complement Medicaid card services.

Q39. If my child is denied coverage under card services for services such as OT, SL/P, Personal Care, or SED, can he use waiver funds to purchase these services?

A. A variation of these services may be available to the child if the child has the assessed need for these services. The federal rules prohibit identical services being on the waiver that are available on the state Medicaid Card Plan. For example, an Occupational Therapist could work with a child on being more independent in the community, or a speech therapist on using language in everyday settings such as a store. These services would typically not meet a medical necessity definition under Medicaid card services, but could be covered by these same professionals as "counseling and therapeutic resources" or "daily living skills" on the waiver. If a service is denied under Medicaid it is also possible to cover it under the waiver.

Q40. Are there good reasons to not access the waiver, related to coordination of funding?

A. No.

VARIOUS RULES UNDER THE WAIVER

Q41. I understand that "intensive service" will include 20-35 hours of therapy per week. How will those hours be broken down across line staff, Seniors, Lead therapist, team meetings, overlap, and travel?

A. Unlike the current card-service system, each child's service plan under the waiver will be individualized, and the break down of services will depend on the overall needs of the child. This will be determined collaboratively with the child's family, therapy team and the county. If disputes remain about the amount of service approved, the state will provide access to an independent assessment of the needed number of hours.

Q42. My 4 year old daughter who has been in therapy for 5 months is receiving 35hrs/wk line therapy, plus a team meeting and overlap time, which amount to an extra 10 billable hours per week. I've been told that when her current PA expires in August, the new PA will be for a total of 35 hours, which will include the team meeting and overlap time. Even though "35 hours per week" sounds the same, it seems to me that my child will be getting at least 10 hrs/wk less therapy. Is this correct?

A. Medicaid does not distinguish team meetings from direct service hours, which means your child has been receiving close to 45 direct service hours per week. Under the waiver, and for PA's that are renewed in the coming months, the maximum number of direct service hours per week will be 35, so yes, your child will be getting fewer hours of therapy. Some providers may change some of their policies, such as the frequency of team meetings, to maximize the number of therapy hours (vs. meeting hours) your child receives.

Q43. If my child is receiving intensive services, but drops to 10-15 hours per week during the school year, will he will be able to continue receiving intensive services (20-35 hours per week) during the summer until his 3 years of intensive are completed?

A. The State requires a minimum of 20 hours per week for an intensive program, but the State also acknowledges that a child's "team" may include school or other agencies, in addition to in-home autism therapy. If the child's individualized service plan stipulates that some service hours will be provided via school or other providers, the number of reimbursed intensive in-home therapy hours may drop below 20 hours per week, as long as the overall treatment program remains at an intensive level of at least 20 face-to-face, direct service hours per week.

Q44. What are the post-intensive service options that will be available to my child under the Children's waiver? It would be helpful if DHFS would send us a list soon, so we can begin planning.

A. The Bureau of Development Disabilities Services has proposed that a variety of services be available under the children's waiver. If a child is receiving intensive in-home services this will be the only waiver service delivered. If the child is in the ongoing waiver we have requested CMS approval of the following types of services: counseling and therapeutic resources, respite, home modifications, adaptive equipment, specialized transportation, family-directed services, family-centered services, and day services related to supported employment as well as child care.

Q45. Will the State be putting together a list of approved “qualified independent clinicians” who can diagnose ASD for the purposes of waiver eligibility?

A. Yes. In the future, an independent diagnosis of ASD will be required prior to the initiation of the intensive in-home autism services. The Division of Health Care Financing is currently developing these evaluation teams and the criteria they will use.

Q46. Should families who are currently seeking diagnoses (with the hope of seeking waiver support for treatment) be using particular doctors (see previous question) to ensure waiver eligibility in the future?

A. No. Families may use any provider for diagnosis at this time. In the future, families seeking the intensive in-home autism service under the waiver will need to have an independent diagnosis of ASD prior to the initiation of the intensive in-home autism services. The Division of Health Care Financing is currently developing these evaluation teams and the criteria they will use.

Q47. DHFS has indicated that the co-pays will amount to very little money. Whether it is a little or a lot, what will happen to this money?

A. Cost share payments will be collected by the state and will be returned to children’s waivers budget for services. Please see the related documents about the cost-share system, which is based upon family income and family size.

Q48. Will I be able to purchase additional hours of in-home autism therapy for my child, above and beyond the hours that Medicaid pays for?

A. Yes. Services in excess of those authorized are considered non-covered services and can be provided to the family if the family agrees to receive and pay for the additional services. Then, the provider may bill the family at a rate negotiated by the family and provider.

Q49. If I purchase additional hours from my provider, are there rules about the rate they can charge me? Does it have to be the same as the rate they charge for covered services? Can a provider drop my child from services if I cannot pay?

A. The rate is negotiated between the family and provider. Medicaid can not dictate fees for services that are not covered by Medicaid. Providers can drop a child from services. Families also have the right to seek services from other providers.

OTHER PROGRAMS

- Q50. Who can we call to learn about support services that can and should be provided by school districts, such as Extended School Year?**
- A. Families should work with their local school IEP Team to discuss needed services for the child’s educational needs and to discuss extended school year criteria. Information about educational services is also available on the Department of Public Instruction web site, www.dpi.state.wi.us.
- Q51. Some providers are trying to develop new programs that will serve kids during the post-intensive portion of the waiver. Who can they call to determine whether their proposed programs could be covered (e.g., not a “duplication of services” with services provided under the waiver or through schools)?**
- A. Providers will work with counties and the Bureau of Developmental Disabilities Services to develop services in response to families identified needs.
- Q52. Families are considering creative ways to “fill in the gaps” of their children’s treatment plans. Who can they call to determine whether their creative solutions could be covered under the waiver?**
- A. Until the Waiver is approved families may call Julie Bryda, Bureau of Developmental Disabilities Services, 262-650-4445 or e-mail her at brydaja@dhfs.state.wi.us.